| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | C | MB NO | 0938-0391 |
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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY IPLETED |
| | | 445262 | B. WING | | | 1 | C 13/2017 |
| NAME OF | PROVIDER OR SUPPLIER | (1 | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CUMBER | RLAND HEALTH CAR | E AND REHABILITATION INC | | | 343 ASHLAND CITY HWY ASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRICIENCY) |) BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | -S | F 0 | 00 | | | |
| | 9/11-13/17. No defic complaint investigat were cited for comp #41475, #42163, #4 PART 483, Required Facilities. | Care and Rehabilitation on ciencies were cited related to cion #41835. Deficiencies laint investigation #41042, 2301, and #42364 42 CFR ments for Long Term Care | | | | | |
| F 224 SS=E | | OHIBIT IEGLECT/MISAPPROPRIATN | F 2: | 24 | | | |
| | abuse, neglect, missi property, and exploi subpart. This include freedom from corpo seclusion and any p | nt has the right to be free from appropriation of resident tation as defined in this es but is not limited to ral punishment, involuntary hysical or chemical restraint the resident's symptoms. | | | | | |
| | 483.12(b) The facilit implement written po | y must develop and olicies and procedures that: | | | | | |
| | | revent abuse, neglect, and ents and misappropriation of | | | | | |
| | (b)(2) Establish polici investigate any such | cies and procedures to allegations, and | | | | | |
| | §483.95, | g as required at paragraph T is not met as evidenced | | | | | |
| | Based on facility po reivew, facility invest and interview, the fa | licy review, medical record tigation review, observation, cility failed to prevent resident narcotic medication | | | | | |
| DODATORY | DIDECTORIS OF PROVIDE | DISTIDUI ED DEDDESENTATIVE'S SIGN | ATLIDE | - | TITLE | | (X6) DATE |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| , | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 4343 ASH | DDRESS, CIT LAND CITY LLE, TN 3 | | CODE | | |
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| | for 7 residents (#1, residents reviewed The findings include Review of facility porevealed "The face "zero tolerance" for management must are free from verba abuse, corporal pur seclusion, and missa report of actual or sacted upon immedia investigation that is Review of facility porevealed "All nurse procedure for account and annually Review of facility Procedure for account and annually Review of facility porevealed :Each do signed out by the nurecord and on the polymetric medication Administ documentation for eaccomplished on the each controlled subsevery shift change is and the nurse going entire medication can and the record shee nursesBoth nurses Control Record indiccompleted; the date cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards, and the number of the subsection of the cards of the subsection of the cards of the subsection of the cards of the subsection of the su | #2, #3, #4, #5, #8, #11) of 16 for abuse. ed: blicy, Abuse, effective 7/2014, illity practices the concept of patient abuse. Nurse strive to ensure the patients I, sexual, physical and mental hishment, involuntary appropriation of property. ANY uspected abuse MUST be atelyConduct a thorough well documented" licy, Controlled Medications, es must be inserviced on the intability for controlled drugs | F 2 | 24 | | | | | |

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| F 224 | notified immediately keys should be don should not leave the Review of facility por Medications, effectifications, effec | or of Nursing (DON) must be y. No exchange of med cart e and the off-going nurse a facility" Olicy, Destruction of ve 7/2/14, revealed "Each commust have a container action of all patients' onsidered for credit or olled medications set to stroyed by the Director of esignee and the consultant ew revealed Resident #1 was lity on 8/1/17 with diagnoses erotic Cardiovascular Disease, ess Disorder, Reflux Disease, Deep Vein tes Mellitus, Hypertension, and ew of the Admission Minimum ted 8/6/17 revealed Resident es Brief Interview for Mental ating he was alert, oriented, is needs known. Continued sident #1 required extensive asfers and bathing; limited essing and grooming; and ting. ew of Physician's Orders ed Resident #1 was ordered milligrams (mg) every 6 | F 2 | | | |
| | | rolled Drug Record revealed Obsolete Event ID: F0U711 | | Facility ID: TN1908 If co | ontinuation sh | eet Page 3 of 38 |
| ORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID, F007 IT | | rading ib. ritiods | | |

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| PREFIX (EACH DEFI | RY STATEMENT OF C CIENCY MUST BE PR Y OR LSC IDENTIFYII | ECEDED BY FULL | ID PREFIX TAG | (EACH O | VIDER'S PLAN OF COF CORRECTIVE ACTION EFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| out at 9:00 PM review reveals on 8/16/17 at Nurse #1. Medical record Administration Oxycodone 7. administered a PM on 8/16/17 evening and n MAR. Review of the Resident #1 w stated he rece PM on 8/15/17 medication du 7:00 AM shift Medical record admitted to the including Diab Dementia, Ob Disorder, Seiz Medical record dated 9/1/17 rethe BIMS indicable to make he Medical record | xycodone 7.5/32 M, 10:00 PM, 2:00 ed Oxycodone w 6:00 AM, all by the formal review of the M Record (MAR) 5/325 mg was do at 3:40 PM on 8/ 7. None of the ot ight shifts were of facility investigatives interviewed of the other pain medic formal the night on and he slept through the color formal the review revealed for eview revealed for eview revealed for eview of the Color for eview of Physical f | revealed ocumented as '15/17 and at 1:33 ther times from the documented on the tion revealed on 8/16/17 and ation about 8:30 eive any pain the 11:00 PM - bugh the night. Id Resident #2 was 4/13 with diagnoses ypertension, Apnea, Bipolar tomy. Quarterly MDS of the time of time | F 22 | 24 | | | |
| for pain. Review of the | Controlled Drug | 4 hours as needed Record revealed | | | | | |
| Oxycodone 7.5 | | gned out at 12:00 Event ID: F0U711 | | Facility ID: TN1908 | If | continuation sh | eet Page 4 of 38 |

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| F 224 | AM, 2:00 AM, 6:00 by Agency Nurse #* record revealed only 12:00 AM but the coperation of the tablet was removed 1 tablet was signed was documented as removed and 25 aft Continued review record at 6:00 AM but the 25 before the tablet the tablet was removed and 6:55 documented removed at 6:45 AM and 6:55 documented removed at 6:45 AM and 6:55 documented removed at 15:45 AM and 6:55 documented removed at 10:53 PM for 8/16/17. Review of the facility Resident #2 was intended at 11:00 PM shift medication during the any increase in her 15 AM and she received admitted to the facility and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted to the facility including Hypertensian and she received admitted t | AM, 6:45 AM, and 6:55 AM, all I. Continued review of the y 1 tablet was signed out at punt was documented as 29 is removed and 27 after the . Further review revealed only out at 2:00 AM but the count was removed. Evealed 1 tablet was signed the count was documented as was removed and 23 after ved. Further review revealed 5 AM Agency Nurse #1 ing 2 tablets each time. The MAR revealed Oxycodone cumented as administered on 1 but nothing was documented as in well as a documented | F 2 | 24 | | | | |

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| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | 1 | 4: | 343 ASHLAND CITY HWY | | |
| CUMBER | RLAND HEALTH CARE | E AND REHABILITATION INC | | N | ASHVILLE, TN 37218 | | |
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| F 224 | Continued From page | ge 5 | F 2 | 24 | | | |
| | 6/30/17 revealed Re | ew of the Annual MDS dated esident #3 scored 13 on the had slight cognitive | | | | | |
| | 7/21/17 revealed Re | hysician's Orders dated esident #3 was ordered ng every 12 hours as a on. | | | | | |
| | 8/5/17 revealed Oxy out at 6:00 PM and was signed out at 6: PM. Continued revie Oxycodone was signand 11:00 PM while 9:30 PM, 10:30 PM, PM. Further review oxycodone was signed AM. Continued revie Oxycodone was signed AM. Continued revie Oxycodone was signed 12:00 AM, 6:00 AM, Further review reveawas signed out at 4: on 8/16/16 it was signed out by Agence of the province of the pr | ned out at 6:00 AM and on out at 12:00 AM and 6:00 ew revealed on 8/14/17 ned out at 12:00 AM, again for 6:30 AM, and 6:50 AM. aled on 8/15/17 Oxycodone 00 PM and 10:00 PM while gned out at 12:00 AM, 6:00 Il of these removals were ey Nurse #1. | | | | | |
| | only documentation Oxycodone was 8/7/ | 17 at 5:30 AM. There was no ne rest of the tablets of | | | | | |
| | | dent #3 on 9/11/17 at 1:50 g in bed asleep. Observation | | | | | |

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| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 4343 | ET ADDRESS, CITY, STATE, ZIP CODE ASHLAND CITY HWY HVILLE, TN 37218 | • | |
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| F 224 | in bed watching TV currently. Medical record revie admitted to the facilincluding Hypertens Disease, Acute Kidn Medical record reviedated 7/27/17 reveathe BIMS, indicating able to make his ne Medical record reviedated 7/20/17 reveating IR (Immediate Fhours as needed for Review of the Contron 8/5/17 Oxycodor and 11:45 P0 AM; on 8/13/17 on 8/14/17 it was sig 6:00 AM; on 8/15/17 and on 8/16/17 it was these removals were #1. Medical record revied documentation on the medications being a Observation of Resi PM revealed Reside Podus boots on both his pain was control Observation of the revealed Reside Podus boots on for the revealed Reside Podus boots on for the reverse of the reverse of the revealed Reside Podus boots on for the reverse of the rever | AM revealed the resident was and stated she had no pain and stated she had no pain are well revealed Resident #4 was ity on 7/20/17 with diagnoses iton, Gastroesophageal Reflux ney Failure, and Paraplegia. We of the Admission MDS aled Resident #4 scored 15 on the was alert, oriented, and eds known. We of Physician's Orders aled an order for Oxycodone 5 Release) 1 tablet every 6 repain. Wolled Drug Record revealed the was signed out at 6:15 PM in 8/12/17 it was signed out at 7:15 AM; and out at 12:00 AM and it was signed out at 7:00 PM as signed out at 1:00 AM. All the signed out by Agency Nurse are worth the MAR revealed no the MAR of any of these administered. We dent #4 on 9/11/17 at 1:40 and #4 sitting up in bed with a lower extremities. He stated | F 2. | 24 | | | |

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| F 224 | asleep with the doo Medical record revie admitted to the facil including Acute Res Pneumothorax, Cer Right Hemiplegia, Heain. Medical record revie dated 8/1/17 reveale the BIMS indicating cognitively. Medical record revie dated 4/28/17 reveal Oxycodone 5/325 m Review of Controller revealed Oxycodone 10:00 PM, 11:00 PM 11:30 PM. Continue Oxycodone was sign 10:30 PM, and 11:00 on 8/6/17 Oxycodon 5:00 PM, and 11:00 revealed on 8/12/17 at 12:00 AM, 4:00 A 8/13/17 it was signe AM. Further review of Oxycodone was sign AM while on 8/15/17 PM, 10:30 PM, 12:0 removals were all sign #1. Medical record review Medical record review #1. | ew revealed Resident #5 was ity on 4/28/17 with diagnoses epiratory Failure, Tension rebrovascular Accident with dypertension, and Chronic ew of the Quarterly MDS and Resident #5 scored 3 on she was severely impaired ew of Physician's Orders alled Resident #5 was ordered and three times daily. d Drug Record dated 8/3/17 er was signed out at 5:00 PM, and dreview revealed on 8/4/17 and out at 5:00 PM, 5:30 PM, D PM. Further review revealed are was signed out at 5:00 AM, PM. Continued review Oxycodone was signed out M, and 6:00 AM while on dout at 12:00 AM and 6:00 | F 2 | 224 | | | |

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| TAG | | ge 8 ident #5 on 9/12/sident lying uncovibly. When the Claim with the resident discovered when the last discovered when the last diministered she sation on the Administered she sation on looking at all cords for all residents who had One night shift as to dents who had one night shift as to dents who had one night shift as to dents stated they ings but had not a those residents a shift they had narro Nurse #1 and the tage of the night strepancies with all tage of the night of the of | /17 at 8:15 /ered in bed, NA entered t but was red. vealed the n Resident #2 8/16/17. d Drug ose of aw the count ablets and shift was 19 ed the s signed out. s with the r and DON the ents. They xycodone o when they hey received of 8/15/17 - had pain required any nd DON and found owed the y began to shift. They I 5 residents | | CROS | S-REFERENCED TO THE | HE APPROPE | RIATE | DA | |
| | were not on the MA Drug Record do not times on the control match the Physiciar ordered on all nurse | R; the times on the match the video led Drug Record 's Orders. Drug ses with access to | ne controlled footage; and do not screens were the | | Facility ID: TN190 | ns. | If continua | tion sheet | Page | 9 of 38 |
| ORM CMS-250 | 67(02-99) Previous Versions | Obsolete | Event ID: F0U711 | | racility ID: TN190 | 70 | ii commua | tion sheet | , age | 0 01 00 |

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| | At this point the age Nurse #1 was to be rotation. The Admin Manager of the staf concerns with Agen Manager reviewed for Agency Nurse #1 from Review of the video 8/16/17 revealed Agency Nurse #1 from Proving the room of Resider medication pass. On PM flipping through then she places an opens the narcotic believes it in the cup. flips out a tablet and through the book as from a card; and adwith water and walk enters the room of Pexits at 8:34 PM with on 1 narcotic. On 8/flipping through narcotic walking on the mwater; walking into the returning with anyth removing a tablet frow the right which were sidents; and cominothing. On 8/16/17 Oxycodone for Resi AM but the video should be a staff of the company to the company of the proving a stablet frow the right which we residents; and cominothing. On 8/16/17 Oxycodone for Resi AM but the video should be a staff of the company of the proving a stablet frow the right which we residents; and cominothing. On 8/16/17 Oxycodone for Resi AM but the video should be a staff of the province of the provin | dent #2 and all were negative. ency was notified Agency removed from the facility istrator spoke with the Branch fing agency regarding her cy Nurse #1. The Branch the videos and terminated om the agency. footage from 8/15/17 and gency Nurse #1 not entering in #1 except for morning in 8/15/17 she is seen at 8:02 the Controlled Drug Records empty cup on the cart. She pox; takes out a pill and She goes to another card; diadds it to the cup; flips third time; removes a narcotic ds it to the cup. She fills a cup is around for 30 minutes. She Resident #4 at 8:25 PM and in h no cups. Resident #4 is only 16/17 at 3:48 AM she is seen cotic cards in the narcotic | F 2 | 224 | | | | |
| | 27/02 00\ Provious Vorsions (| | | Fac | ility ID: TN1908 If continua | tion sheet I | Page 10 | of 38 |

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| | | & MEDICAID SERVICE | | | | OMB NO. | 0938-0391 |
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| F 224 | 9/12/17 at 1:35 PM revealed she was the PM. Continued interview recontrolled Drug Redose was given. Conshe notes the date withdrawal as well and 2 tablets were interview revealed she noted and 2 tablets were interview revealed signed out at 6:15 And she pulled the sign Administrator. Interview with the And and 2:20 PM in the Administrator. Interview with the And and and 2:20 PM in the Administrator. Interview with the And and and DON determined in and DON | stered Nurse (RN #1) or in the conference room he nurse on 7:00 AM - 3 rview revealed Resident I asked for something forwealed RN #1 checked cord to see when the last and times of Oxycodone as the fact the count at 1 one remaining and at 7: remaining. Further interest 1 tablet was removed at others. Confishe also saw Oxycodone AM and again at 6:45 AM out sheet and took it to definition of the sign out sheet to he she and the DON beganets from other residents to the Oxycodone of Red and all were negative. | :00 :#2 or pain. the st led e 1:00 00 AM view t times tinued e A so the at aled ner . All esident In ator ey es When otrator e she ager | 224 | | | |
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| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 4343 A | TADDRESS, CITY, STATE, ZIP CODE SHLAND CITY HWY VILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 224 | Oxycodone signed of Record at various ticorresponding documedication adminissigned out consister Review of video foothrough narcotic car Record and removing failed to show Agen rooms of these resimedications were signed and removing the second and removing failed to show Agen rooms of these resimedications were signed at the second and show a signed and the second and shift but Agout Oxycodone as a furing that time. Medical record review admitted to the facility and the second review of the facility ordered Oxycodone pain. Review of the facility 3/13/17 at 2:00 AM (LPN) #5 and #6 signed Narcotic Control Recoxycodone 5/325 mbox. Continued review of the facility of the signed shows and the signed shows of the facility of the signed shows. Continued review of the signed shows are signed as the signed shows of the facility of the signed shows of the signed | ents #1, #2, #3, #4, and #5 had out on the Controlled Drug mes but there was no umentation on the MAR of tration. The Oxycodone was ntly by Agency Nurse #1. Itage showed her flipping rds and the Controlled Drug ng narcotics. The videos also ncy Nurse #1 entering the dents at the times the igned out. Residents #1, #2, ert and oriented, stated they done during the 11:00 PM - gency Nurse #1 had signed naving been administered ew revealed Resident #8 was lity on 12/7/16 with diagnoses lulitis, Congestive Heart in, Hypertension, Obstructive and Respiratory Failure. | | 224 | | | |
| ODM CMC 25 | 87/02 00) Previous Versions | Obsolete Event ID: F0U7 | '11 | Facility ID | : TN1908 If cont | inuation sheet | Page 12 of 38 |

| | DO EOR MEDICARE | & MEDICAID SERVICES | | | 01 | MB NO. 0 | 938-0391 |
|--------------------------|--|--|---------------------|--|----------------------------|----------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | TIPLE CONSTRUCTION | | (X3) DATE S COMPL | |
| | | 445262 | B. WING | | | C 09/13 | 3/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | STREET ADDRESS, CITY, STATE, 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD THE APPROPE | BE | (X5) COMPLETION DATE |
| F 224 | Narcotic Control Renot destroyed. Furth with 27 tablets of O with the sign-out shrevealed the medication cart were Oxycodone was not revealed the two nuthe locked box and access to the box with negative. Continued previous Administrational lock box but was not Review of a written 3/21/17 revealed "him to drop a narco patient, [Resident #Oxycodone 5/325 in nurse opened top of the med card was in who then had to for get med to drop. But had dropped. This in both nurses left the Review of a written revealed "I went to Oxycodone due to the transport of the amount wrapped with the na applied. Meds with dropped and door show into box and [walked out of med to the control of the side of the med to the proposed and door show into box and [walked out of med to the control of the med to the proposed and door show into box and [walked out of med to the control of the med to the proposed and door show into box and [walked out of med to the control of the proposed and door show into box and [walked out of med to the control of the proposed and door show into box and [walked out of med to the proposed and door show into box and [walked out of med to the proposed and door show into box and [walked out of med to the proposed and door show into box and [walked out of med to the proposed and door show into box and [walked out of med to the proposed and the | ecord that the Oxycodone was her review revealed the card xycodone was missing along eet. Continued review ation room as well as the researched and the card of the found. Further review arses who placed the card in another nurse who had were all drug tested and were dinvestigation revealed the ator has obtained a key to the of available for drug testing. Statement from LPN #5 dated and 3/13/17 [LPN #6] asked tic card for a discharged all. The card contained are graph and the card for a discharged are graph as the nurse [LPN #6] cefully shut the door twice to oth nurses then verified med and room" Statement from LPN #6 of discard [Resident #8] the resident being discharged. It to the med room. I logged [LPN #5] had key to drop box LPN #5] and myself both of meds on card. Card was arcotic sheet and rubber band sheet put into box. Med lammed x 2. Med dropped LPN #5] locked box. We both room together" | F 2 | | If continuati | on sheet Pa | age 13 of 38 |
| ORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: F0U711 | | Facility ID: TN1908 | If continuati | on sheet Pa | age 13 of 38 |

| | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO | . 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | E SURVEY IPLETED |
| | | 445262 | B. WING | | | C /13/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 224 | Review of a written Nurse (RN) #3 who placing medications "On 3/13/17 I with narcotic destruction narcotic was placed the medication room narcotics removed thox. The narcotic be afterwards" Interview with LPN at the nurses' station of disposed of the Oxy She completed the lock box. They had pills remaining in it. sheet around the case a rubber band. They and heard it fall. LP both left the medical Interview with the Admithree nurses were described to the lock box but could not be drug the confirmed the card at even after a complemedication room, and Medical record revised mitted to the facili including Chronic Odisease, Diabetes Medical places. Schizophrenia, Obs. | statement from Registered was the only other person into the locked box revealed essed and documented a with another nurse. The in the narcotic box located in nof the facility. All cards of from the cart dropped into the box was locked back #6 on 9/12/17 at 6:45 AM at evealed she and LPN #5 recodone from Resident #8. To while LPN #5 opened the a card of Oxycodone with 27 They wrapped the sign-out ard of pills and secured it with a dropped the card in the box N #5 locked the box and they tion room. Idministrator on 9/13/17 at inistrator's office revealed the lrug tested and were negative. The revealed the previous diaintenance make him a key he had been terminated so ested. Further interview and 27 pills were not located ted search of the lock box, | F 2: | 24 | | |
| ORM CMS-25 | 67(02-99) Previous Versions | | | Facility ID: TN1908 If conti | nuation sheet | Page 14 of 38 |

| CENTE | RS FOR MEDICARE | & MEDICAID S | SERVICES | | | | OMB NO. | 0938-0391 |
|--------------------------|--|---|---|--------------------|------|--|-------------|----------------------------|
| | T OF DEFICIENCIES | (X1) PROVIDER/SU | | I ' ' | | LE CONSTRUCTION | | E SURVEY IPLETED |
| AND PLAN (| OF CORRECTION | IDENTIFICATIO | IN NUMBER. | A BUILD | DING | | | C |
| | | 445 | 262 | B. WING | | | | 13/2017 |
| NAME OF | PROVIDER OR SUPPLIER | 110 | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 10/2011 |
| OUMBE | DI AND UCALTU CAD | E AND DELIABIL | TATION INC | | 4 | 1343 ASHLAND CITY HWY | | |
| COMBE | RLAND HEALTH CAR | E AND REHABIL | TATION INC | | N | NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | | TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF | ED BY FULL | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | Continued From particles Heart Failure, and Continued From particles Heart Failure, and Continued Review of the BIMS, indicating impaired. Medical record review dated 7/12/17 reveal to the facility on 6/2/17 reveal to the facility on 6/2/17 record revealed und Quantity Dispensed with 30. Further review of the facility Pharmacy was called delivered to the facility of the facility | ew of the Quarte ed Resident #11 g she was slightle ew of Physician' aled Resident #1 very 8 hours as rolled Drug Record 10/325 mg wery. Continued revider Quantity Record to 10/325 mg wery. The 60 had begiew revealed the don 9/5/17 by LI y investigation red and verified 6 lity. The delivery which showed 6 and verified 6 lity. The delivery which showed 6 and card with 30 rolled Drug Record been located. Ident #11 on 9/1 bed asleep with and a dressing gery. | erly MDS I scored 12 on ly cognitively s Orders I1 was ordered needed. ord revealed e delivered to iew of the ceived and en overwritten e only PN #2. evealed the 0 tablets were or manifest was 0 tablets tablets of ord were 3/17 at 9:35 somewhat over her right | F 2 | 224 | | | |
| SS=D | 483.12(a)(3)(4)(c)(1 ALLEGATIONS/IND | IVIDUALS | | ГΖ | | Hith ID TM COD | ation about | Page 45 of 20 |
| ORM CMS-250 | 67(02-99) Previous Versions (| Upsolete | Event ID: F0U711 | | rac | cility ID: TN1908 If continu | anon sneet | Page 15 of 38 |

DELIMITATION THE PROPERTY OF T

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | 0 | MB NO. | 0938-0391 |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ISTRUCTION | 4 31 | | SURVEY PLETED |
| | | 445262 | B. WING | | - | | 09/1 | 3/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET | ADDRESS, CITY, STATE, ZIP C | ODE | - | |
| | | | | 4343 AS | SHLAND CITY HWY | | | |
| CUMBER | RLAND HEALTH CARE | E AND REHABILITATION INC | | NASH | VILLE, TN 37218 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD | BE | (X5) COMPLETION DATE |
| F 225 | Continued From pa | ge 15 | F 2 | 25 | | | | |
| | 483.12(a) The facili | ty must- | | | | | | |
| | (3) Not employ or of who- | therwise engage individuals | | | | | | |
| | | guilty of abuse, neglect, propriation of property, or court of law; | | | | | | |
| | núrse aide registry | ng entered into the State concerning abuse, neglect, atment of residents or their property; or | | | | | | |
| | or her professional body as a result of a | ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. | | | | | | |
| | licensing authorities actions by a court of | ate nurse aide registry or any knowledge it has of f law against an employee, e unfitness for service as a facility staff. | | | | | | |
| | (c) In response to a exploitation, or mist | llegations of abuse, neglect, reatment, the facility must: | | | | | | |
| | abuse, neglect, explincluding injuries of misappropriation of reported immediatel after the allegation is cause the allegation | lleged violations involving loitation or mistreatment, unknown source and resident property, are ly, but not later than 2 hours s made, if the events that involve abuse or result in , or not later than 24 hours if | | | | | | |
| OPM CMS-250 | 37(02-99) Previous Versions (| Obsolete Event ID: F0U711 | | Facility ID: | TN1908 If c | ontinuati: | on sheet f | Page 16 of 38 |

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| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | Ol | MB NO. | 0938 | -0391 |
|--------------------------|--|--|--------------------|---|---|-------------------|------------------------|----------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | - | (X3) DATE COMF | SURV | |
| | | 445262 | B. WING | | | 09/1 | ; 3/20 [.] | 17 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | STREET ADDRESS, CITY, ST 4343 ASHLAND CITY HW NASHVILLE, TN 37218 | Y | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTI CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPE FICIENCY) | BE | COMP | X5) LETION ATE |
| F 225 | the events that cau abuse and do not recommendate the administrator of officials (including the adult protective serfor jurisdiction in local accordance with Staprocedures. (2) Have evidence thoroughly investigation of the exploitation, or missinvestigation is in possible to the administrator or his representative and with State law, including the alleged violatic corrective action more than the alleged violatic corrective a | ise the allegation do not involve esult in serious bodily injury, to fi the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in that all alleged violations are atted. It all alleged violations are atted. It is of all investigations to the story of the other officials in accordance and to other officials in accordance and to the State Survey orking days of the incident, and ion is verified appropriate and ion is verified appropriate and to other officials in accordance and the state of the incident, and ion is verified appropriate and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. It is not met as evidenced and interview, the perly complete an investigation of 17 residents reviewed. | F 2 | 25 | | | | |
| | including Bipolar Di | isorder, Anxiety Disorder, | | Facility ID: TN1908 | If continuat | ion sheet I | Page 1 | 17 of 38 |

DEPARTMENT OF THEMETITIAND HOMING SERVICES

| CONTINUENCE OF PROVIDER OR SUPPLIER LAMB OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC DATE OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC DATE OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC DATE OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC DATE OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC DATE OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC DATE OF PROVIDER OR SUPPLIER SUMMAY STATEMENT OF DEFICIENCIES PROVIDER SHAN OF CORRECTION GRACH DEPROCEPT WAS TO THE PROVIDER OF PROVIDER OF THE PROVIDE | CENTER | RS FOR MEDICARE | & MEDICAID S | ERVICES | | | | | 0938-0391 |
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| NAME OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC CHAIN TO SUMMANY STATEMENT OF DEPOLISACISE OF PRECEDED BY PLUL PROVIDERS FLAN OF CORRECTION SHOULD BE PRECEDED BY PLUL PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF TAKE THAN THE PROVIDER OF THE PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE OF THE PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE OF THE PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE OF THE PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE OF THE PROVIDERS FLAN OF CROSS-REFERENCE OF THE APPROPRIATE OF THE PROVIDERS FLAN OF THE PROVIDERS FLAN OF CROSS-REFERENCE OF THE APPROPRIATE OF THE PROVIDERS FLAN OF THE PROVID | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SU | PPLIER/CLIA | , , , | | | COM | IPLETED |
| CUMBERLAND HEALTH CARE AND REHABILITATION INC Machine Machine | | | 4452 | 262 | B, WING | | | | |
| CUMBERLAND HEALTH CARE AND REHABILITATION INC (XX) ID SUMMARY STATEMENT OF DEFICIENCIES) FREEK (EACH DEFIGIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 17 Brown-Sequard Syndrome, Drug or Chemical Induced Diabetes Melitus, Left Foot Drop, Hyperlipidemia and Necrotizing Vasculopathy. Medical record review of the Quarterly Minimum Data Set dated 8/17/17 revealed Resident #9 had a Brief Interview of Mental Status of 15, indicating she was cognitively intact. Review of a facility completed abuse investigation revealed a list of staff interviewed on 9/6/17 by the Assistant Director of Nursing/Registered Nurse (RN) #2 and the Risk Manager/Licensed Practical Nurse (LPN) #4. There was a hand written list with staff names and short statements beside each name (8 total) all in the same handwriting. There were 8 individually hand written statements dated 9/6/17, all in the same handwriting to different handwriting from the list. Interview with RN #2 on 9/12/17 at 3:15 PM in her office revealed she wrote the list of the staff names and what that staff fold her located in the facility completed investigation of abuse to Resident #9. Interview with LPN #4 on 9/12/17 at 3:43 PM in her office revealed she wrote the 8 hand written individual statements focated the facility completed investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility completed investigation. LPN #4 confirmed she failed to obtain written statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility failed to obtain written statements from the staff that were interviewed and Resident #9 in the | NAME OF | PROVIDER OR SUPPLIER | | | | | | | |
| F 225 Continued From page 17 Brown-Sequard Syndrome, Drug or Chemical Induced Diabetes Mellitus, Left Foot Drop, Hyperlipidemia and Necrotizing Vasculopathy. Medical record review of the Quarterly Minimum Data Set dated 8/17/17 revealed Resident #9 had a Brief Interview of Mental Status of 15, indicating she was cognitively intact. Review of a facility completed abuse investigation revealed a list of staff interviewed on 9/6/17 by the Assistant Director of Nursing/Registered Nurse (RN) #2 and the Risk Menagagraticensed Practical Nurse (LPN) #4. There was a hand written list with staff names and short statements beside each name (8 tota) all in the same handwriting. There were 8 individually hand written statements dated 9/6/17, all in the same handwriting but a different handwriting from the list. Interview with RN #2 on 9/12/17 at 3:15 PM in her office revealed she wrote the list of the staff names and what that staff told her located in the facility completed investigation. RN #2 confirmed she failed to obtain written statements from the staff for the investigation of abuse to Resident #9. Interview with IPN #4 on 9/12/17 at 3:45 PM in her office revealed she wrote the 8 hand written individual statements located the facility completed investigation. LPN #4 confirmed she failed to obtain written statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office revealed she wrote the 8 hand written individual statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility failed to obtain written statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility failed to obtain written statements form the staff that were interviewed and Resident #9 in the | CUMBER | RLAND HEALTH CARI | E AND REHABILI | TATION INC | | | IASHVILLE, TN 37218 | | |
| Brown-Sequard Syndrome, Drug or Chemical Induced Diabetes Mellitus, Left Foot Drop, Hyperlipidemia and Necrotizing Vasculopathy. Medical record review of the Quarterly Minimum Data Set dated 8/17/17 revealed Resident #9 had a Brief Interview of Mental Status of 15, indicating she was cognitively intact. Review of a facility completed abuse investigation revealed a list of staff interviewed on 9/6/17 by the Assistant Director of Nursing/Registered Nurse (RN) #2 and the Risk Manager/Licensed Practical Nurse (LPN) #4. There was a hand written list with staff names and short statements beside each name (8 total) all in the same handwriting. There were 8 individually hand written statements dated 9/6/17, all in the same handwriting but a different handwriting from the list. Interview with RN #2 on 9/12/17 at 3:15 PM in her office revealed she wrote the list of the staff names and what that staff told her located in the facility completed investigation. RN #2 confirmed she failed to obtain written statements from the staff for the investigation of abuse to Resident #9. Interview with LPN #4 on 9/12/17 at 3:43 PM in her office revealed she wrote the 8 hand written individual statements located the facility completed investigation. LPN #4 confirmed she failed to obtain written statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility failed to obtain written statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility failed to obtain written statements for the staff that were interviewed and Resident #9 in the | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDE | D BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE | COMPLETION |
| were interviewed and Resident #9 in the | F 225 | Brown-Sequard Syr Induced Diabetes Myperlipidemia and Medical record revie Data Set dated 8/17 a Brief Interview of she was cognitively revealed a list of stathe Assistant Direct Nurse (RN) #2 and Practical Nurse (LP written list with staff beside each name handwriting. There written statements of handwriting but a dilist. Interview with RN # office revealed she names and what the facility completed in she failed to obtain staff for the investigation of abuur Interview with LPN: her office revealed individual statement completed investigation of abuur Interview with the A 3:50 PM in her office | modrome, Drug or Mellitus, Left Food Necrotizing Vassew of the Quarter 7/17 revealed Reference Mental Status or intact. completed abuse aff interviewed or of Nursing/Reference Mental Status or intact. completed abuse aff interviewed or of Nursing/Reference Mental Mental Status or intact. completed abuse aff interviewed or of Nursing/Reference Mental Ment | erly Minimum esident #9 had f 15, indicating e investigation in 9/6/17 by egistered er/Licensed as a hand out statements e same ally hand in the same ing from the staff ocated in the #2 confirmed ints from the o Resident #9. 1 3:43 PM in hand written cility infirmed she for the fee. | F2 | 225 | | | |
| | DBM CMC OF | were interviewed ar | nd Resident #9 i | n the | | Fac | cility ID: TN1908 If continu | ation sheet | Page 18 of 38 |

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| | DO FOR MEDICADE | & MEDICAID SERVICES | | | C | MB NO. | 0938-0391 |
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| | | | 1 (Y2) MIII | TIPI | LE CONSTRUCTION | | SURVEY |
| STATEMENT AND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | PLETED |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | A. BOILE | ,,,,, | | | |
| | | 445262 | B: WING | | | 09/ | 13/2017 |
| NAME OF E | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 4 | 343 ASHLAND CITY HWY | | |
| CUMBER | RLAND HEALTH CAR | E AND REHABILITATION INC | | N | NASHVILLE, TN 37218 | | |
| | OLIMANA DV CTA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | N | (X5) |
| (X4) ID PREFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOUL | D BE | COMPLETION DATE |
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| | | 4.0 | | ٠ | | | |
| F 225 | · | | FZ | 225 | | | |
| | investigation of abu | | | | | | |
| | | ON OF MEDICALLY | F 2 | 250 | | | |
| SS=D | RELATED SOCIAL | SERVICE | | | | | |
| | (d) The facility mus | t provide medically-related | | | | 1 | |
| | social services to a | ttain or maintain the highest | | | 4 | | |
| | practicable physica | I, mental and psychosocial | | | | | |
| | well-being of each | resident. | | | | | |
| | This REQUIREMEN | NT is not met as evidenced | 1 | | | | |
| | by: | | į. | | | | |
| | Based on facility po | olicy review, medical record | | | | | |
| | review and interviev | w the facility failed to provide ocial services to attain or | | | | | |
| | maintain the highes | st practicable physical, mental | | | | 1 | |
| | and psychosocial w | vell-being for 1 resident (#10) | 1 | | | | |
| | of 17 residents revi | | Ì | | | | |
| | | | | | | | |
| | The findings include | ed: | | | | | |
| | Review of facility po | olicy, Social Services, dated | İ | | | | |
| | March 2016 revealed | ed "Social workers are to | 1 | | | | |
| | | he patient and their families | 1 | | | | |
| | and other individua | Is involved with the patient's | | | | | |
| | care. Social worker | s are to be the patient's they receive appropriate care | | | | | |
| | and treatment" | tiley receive appropriate care | | | | | |
| | and troutilline | | | | | | |
| | Medical record revi | ew revealed Resident #10 was | | | | | |
| | admitted to the faci | lity on 4/9/12 with diagnoses | | | | | |
| | including Bilateral E | Blindness, Type II Diabetes | | | | | |
| | Mellitus, Vascular Diagonal Control | Dementia, Peripheral Vascular | | | | | |
| | | sophageal Reflux Disease, rthropahty, Hypertension, | | | | | |
| | Hypokalemia Anen | nia, Rheumatoid Arthritis, | 1 | | | | |
| | Stage 3 Pressure L | licer of Left Buttocks & Muscle | 1 | | | | |
| | Wasting & Atrophy. | | | | | | |
| | | | | | | | |
| | Medical record revi | ew of the Quarterly Minimum | | | | | |
| | | | | _ | If confirm | tion chact | Dage 10 of 20 |
| ORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: F0U71 | 1 | Fa | cility ID: TN1908 If continua | mon sneet | Page 19 of 38 |

| | O COD MEDICADE | | | | Ol | MB NO. | 0938-0391 |
|--------------------------|--|--|--------------------|---|---------------------------------|------------|----------------------------|
| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE CONSTRUCTION | | (X3) DATE | SURVEY |
| AND PLAN C | F CORRECTION | IDENTIFICATION NUMBER: | A BUILD | NG | | COMP | PLETED |
| | | 445262 | B. WING | | | | 3/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | STREET ADDRESS, CITY, STATE 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD TO THE APPROPI | BE | (X5) COMPLETION DATE |
| F 250 | Data Set dated 6/24 had a Brief Interview indicating she was surther review reversimpairment of the lost steady, only able to with moving from semoving on/off toilet transfer. Medical record revied 5/18/17 revealed extra touched the ankle at Medical record revied dated 5/19/17 revealed touched. Very painful precall any injury to a regarding pain to ptolevel for today which Medical record revied dated 5/19/17 revealed and mildly the distal tibia and disjoint space. The borrow there acute fracture findings Acute fractional fibula" Medical record revied findings showed cordisplaced acute fractions of the fractions of the findings showed cordisplaced acute fractions | ge 19 A/17 revealed Resident #10 W for Mental Status of 4 severely cognitively impaired. aled the resident had no ower extremities and was not stabilize with staff assistance eated to standing position, and surface-to-surface ew of a Clinical Note dated dema in right ankle. Resident al grimaces when the nurse and declined to get out of bed. ew of a Physician Assessment aled "Pt's [patient's] rt [right] memoatous, possible deformity with] palpitation. Pt doesn't ankle. Was called last night ship/ankle, ordered uric acid in is [negative] will get xray" ew of a Radiology Report aled "There are comminuted by displaced acute fractures of listal fibula, well above the mes are osteopenic. There wing of the ankle joint. No s seen. No other incidental eture of the distal tibia and ew of a Clinical Note dated the Nurse Practitioner (NP) the resident's right ankle. The mminuted and mildly eture of the tibia and fibula NP ordered the resident to | F 2 | 50 | | | |
| ORM CMS-25 | 67(02-99) Previous Versions | | | Facility ID: TN1908 | If continuati | on sheet F | Page 20 of 38 |

| CENTER | RS FOR MEDICARE | & MEDICAID | SERVICES | | | | <u>ОМВ ИО.</u> | 0938-0391 |
|--------------------------|--|--|--|--------------------|-----|--|----------------|----------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SU | UPPLIER/CLIA | l ` ′ | | LE CONSTRUCTION | | E SURVEY IPLETED |
| ANDIDANO | CONNECTION | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | A. BUILL | ING | | | С |
| | | 445 | 262 | B. WING | | | 09/ | 13/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CUMBER | LAND HEALTH CAR | E AND REHABIL | ITATION INC | | | 343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENCY REGULATORY OR L | TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INI | ED BY FULL | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 250 | Continued From particles be sent to Emergent Medical record revie 5/19/17 revealed Resident was to follow Physician within 5 to Review of a medical revealed Resident was appointment with a review revealed " | ew of an ED repesident #10 had e" which was sow-up with the Co 7 days. If record report #10 had a follow or orthopedic spotent nursing facilitating. She was seen of at nursing facilitating. She was pately never follower with her daughter why they the followup infrand that the daughter says should do it where are the cular tib-fib fracture of the accuration of the ER of until now part will have to be the for trying to go in breakdown are anything. She at that we treat we treat where in a shore fracture site. Healing will see cast off, get and her symptoms olded removable. | cort dated d a "tib-fib splinted. The Orthopedic dated 7/21/17 v-up ecialist. Further on May 19, ty showed a placed in a wed up until ughter. I never brought formation that I ughter had with ne just thought en we touched gThere is a distal tibia and ankleRight ture sustained and told to tient is not an alance the et the bone to not this really is may have a with bracing t leg cast for dopefully this ee her back in a other set of s. She may be le splint, that | F 2 | 250 | | | |
| ORM CMS-25 | 67(02-99) Previous Versions | | Event ID: F0U711 | | Fac | cility ID: TN1908 If continu | ation sheet | Page 21 of 38 |

DELLEGATION ST. THE ST. T. ST.

| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | | The second secon | 0938-0391 |
|--------------------------|--|---|--------------------|--|---|--|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | TIPLE CONSTRUCTION | | СОМ | E SURVEY PLETED |
| | | 445262 | B. WING | | | 09/ | 13/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | STREET ADDRESS 4343 ASHLAND NASHVILLE, T | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (FACH C | VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 250 | March 2017 until Se was never seen by medical record date revealed "[Reside services on this dat provided and will be staff review. This so [Resident #10] with they arise" Interview with the S 9/12/17 at 4:30 PM responsible for mak SW #1 stated he was had a fracture. SW Resident #10 a follophysician. SW #1 st Resident #10 from 12017. Interview with the Additional to ensure Resident orthopedic appointment of the provided she exhause contact with responsible for make the provided she with the pr | #10's medical records from ept 2017 revealed the resident social services. Review of a ed 3/6/17 by social services ent #10] received mental health e. A clinical noted has been e scanned into the system for ocial worker will assist any social services needs as ocial Worker (SW) #1 on in his office revealed he was sing follow-up appointments. As not aware Resident #10 #1 confirmed he did not make ow-up as ordered by the ED tated he had not seen timeframe May 2017-July dministrator on 9/12/17 at e confirmed the facility failed #10 received a follow-up | F 2 | 50 | | | |
| | or maintain the high | elated Social Services to attain lest practicable physical, social well-being for Resident | | | | | |
| ORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: F0U711 | | Facility ID: TN1908 | If contin | nuation sheet | Page 22 of 38 |

| STATEMENT OF DESCRIPTIONS OX1 PHICAGION MINERS A45262 NAME OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC OX4) ID SUMMANY STATEMENT OF DESCRIPTIONS FREET ADDRESS, CITY, STATE, ZIP CODE 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 SUMMANY STATEMENT OF DESCRIPTIONS FREET ADDRESS, CITY, STATE, ZIP CODE 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 PROVIDER OR PROVIDER OR SUPPLIER COMBERLAND HEALTH CARE AND REHABILITATION INC OX4 ID FREETY ASH VILLE, TN 37218 PROVIDER SPLAN OR CORRECTION FREETY ASH VILLE, TN 37218 PROVIDER SPLAN OR CORRECTION OSER S | CENTER | & MEDICAID SE | RVICES | | | | <u> </u> | MB NO. | 0938-0391 | |
|--|---------------|--|--|---|--------|--------------|---|------------|------------|---------------|
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC SIMMARY STRINGEN OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL FROM THE PROVIDERS PLAN OF CORRECTION FROM TAGE) F 309 Continued From page 22 F 309 SSEE FOR HIGHEST WELL BEING 483.24 (A83.26/k/li) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident with the resident season and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' shore parallel by the facility must ensure that residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' posls and preferences. (i) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUP | PLIER/CLIA | 1 ` ' | | | | | |
| CUMBERLAND HEALTH CARE AND REHABILITATION INC (RACH DE PREETIX (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR ISC IDENTIFYING INFORMATION) F 309 Continued From page 22 F 309 483.24, 483.25(k)(f) PROVIDE CARE/SERVICES SS=E FOR HIGHEST WELL BEING Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care assessment and plan of care. 483.26 Quality residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (i) Dialysis. The facility must ensure that residents who require dialysis receives such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: | | | 44526 | 32 | | | | | | |
| FREEN TAG FOR THE PROPERTY OF A LICENSE PRO | | | E AND REHABILIT | ATION INC | | 4343 A | SHLAND CITY HWY | ODE | | |
| F 309 SS=E FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED | BY FULL | PREFIX | | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD | BE | COMPLETION |
| by: | F 309 SS=E | 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of life Quality of life is a furth applies to all care arresidents. Each residents. Each residents. Each residents active as a facility must provide services to attain or practicable physical well-being, consiste comprehensive assembles to all treatmestable physical well-being, consiste comprehensive assessment of a residents residents received accordance with propractice, the comprehensive and the residents with profession of the comprehensive and the residents who requires and the residents who requires revices, consistent of practice, the comparence of practice, and the repreferences. | PROVIDE CARE ELL BEING e ndamental princip nd services provident must receive the necessary care maintain the high mental, and psy nt with the reside ressment and plan are fundamental prince the facility we treatment and offessional standa rehensive person- residents' choices refollowing: nt. sure that pain ma s who require successional standard person-centered reality must ensure re dialysis receive with professional prehensive person- residents' goals are residents' goals are residents' goals are | ole that ded to facility ve and the are and nest chosocial nt's n of care. ciple that vided to rehensive must ensure care in rds of centered , including nagement is ch services, ls of practice, care plan, nees. that e such I standards in-centered ind | | | | | | |
| | | by: | | | | Facility ID: | TN1908 If | continuati | on sheet F | Page 23 of 38 |

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | . 0938-0391 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | COM | E SURVEY IPLETED |
| | | 445262 | B, WING | | 1 | C 13/2017 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4343 ASHLAND CITY HWY | | |
| CUMBER | | E AND REHABILITATION INC | | NASHVILLE, TN 37218 | TION | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 309 | Based on facility poreview, facility invest and interview, the facility policy for 1 refailing to follow Phys. (#12, #10, #3, #14, facility policy for 1 reviewed. The findings include Review of facility policy for 1 reviewed. The findings include Review of facility policy for 1 reviewed. The findings include Review of facility policy for expected "Each do signed out by the nursecord and on the padministration Record for effectiveness shemal expected for effectiveness shemal expected for missing mesheet must be done must sign the Narcotthe count has been number of medicatic controlled drug record for missing (DON) mand the off-going nufacility" Medical record reviewed admitted to the facilincluding Chronic Killing C | policy review, medical record stigation review, observation, acility failed to provide care by sician's Orders for 6 residents #17) and failed to follow the esident (#12) of 17 residents ed: plicy, Controlled Drug edure, effective 7/2014, ose administered is to be urse on the controlled drug atient's eMAR [Medication ord]. Follow-up documentation ould be accomplished on the ount of each controlled audited at every shift change gon duty and the nurse going cks of the entire medication edications and the record exposed by both nursesBoth nurses of completed; the date, time, on cards, and the number of | F3 | 09 | | |

| (FACH DESIGNEY MIST BE PRECEDED BY FILL PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPL | CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | OMB NO. | . 0938-0391 |
|--|------------|--|---|---------|---------------------|---|-------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER CUMBERLAND HEALTH CARE AND REHABILITATION INC (X4) ID PREFIX TAG COMPLETIVE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG CONTINUED From page 24 Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/17/17 revealed Resident #12 scored 1 on the Brief Interview for Mental Status (BIMS) indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 5/31/17 revealed Resident #12 was ordered Hydrocodone/APAP 5/325 milligrams (mg) 1/2 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed Hydrocodone was signed out on 8/27/17 or 8/28/17 by Licensed Practical Nurse (LPN #1). | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | l ' ' | | | | |
| CUMBERLAND HEALTH CARE AND REHABILITATION INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 24 Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/17/17 revealed Resident #12 scored 1 on the Brief Interview for Mental Status (BIMS) indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 5/31/17 revealed Resident #12 was ordered Hydrocodone/APAP 5/325 milligrams (mg) 1/2 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed Hydrocodone was signed out on 8/31/17 and below it were 2 tablets signed out on 8/27/17 or 8/28/17 by Licensed Practical Nurse (LPN #1). | | | 445262 | B. WING | | | 1 | |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 24 Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/17/17 revealed Resident #12 scored 1 on the Brief Interview for Mental Status (BIMS) indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 5/31/17 revealed Resident #12 was ordered Hydrocodone/APAP 5/325 milligrams (mg) 1/2 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed Hydrocodone was signed out on 8/31/17 and below it were 2 tablets signed out on 8/27/17 or 8/28/17 by Licensed Practical Nurse (LPN #1). | | | E AND REHABILITATION INC | | 4343 ASHLANI | D CITY HWY | | |
| Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/17/17 revealed Resident #12 scored 1 on the Brief Interview for Mental Status (BIMS) indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 5/31/17 revealed Resident #12 was ordered Hydrocodone/APAP 5/325 milligrams (mg) 1/2 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed Hydrocodone was signed out on 8/31/17 and below it were 2 tablets signed out on 8/27/17 or 8/28/17 by Licensed Practical Nurse (LPN #1). | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFI | PRO (EACH | OVIDER'S PLAN OF CORRECTI H CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO | LD BE | (X5) COMPLETION DATE |
| out on 6/26/17, 7/14/17, 7/12/17, and 7/31/17 and 1/2 wasted was documented but there was no signature by the second nurse. Further review revealed 1 tablet signed out on 8/7/17, 8/23/17, 8/25/17, 8/26/17, 8/31/17 but the other had not been changed from 1/2 tablet. Observation of Resident #12 on 9/13/17 at 11:50 AM revealed her seated in her wheelchair in front of the overbed table with a finished lunch tray on it. Her arms were crossed; she was leaning to the left; and was asleep. Medical record review revealed Resident #3 was admitted to the facility on 7/8/16 with diagnoses including Hypertension, Chronic Kidney Disease, Diabetes Mellitus, Dementia, and Decreased Mobility. Medical record review of the Annual MDS dated 6/30/17 revealed Resident #3 scored 13 on the BIMS indicating she had slight cognitive | F 309 | Medical record revied Data Set (MDS) data #12 scored 1 on the Status (BIMS) indiction impaired cognitively. Medical record revied dated 5/31/17 reveatordered Hydrocodor (mg) 1/2 tablet ever Review of the Contr. Hydrocodone was selow it were 2 tables 8/28/17 by Licensed Continued review record out on 6/26/17, 7/14/7/31/17 and 1/2 was there was no signat Further review reves 8/7/17, 8/23/1 | ew of the Quarterly Minimum ted 8/17/17 revealed Resident e Brief Interview for Mental ating she was severely //. ew of Physician's Orders aled Resident #12 was ne/APAP 5/325 milligrams by 6 hours as needed for pain. rolled Drug Record revealed signed out on 8/31/17 and ets signed out on 8/27/17 or depractical Nurse (LPN #1). Evealed 1/2 tablet was signed 4/17, 7/17/17, 7/25/17, and ested was documented but ture by the second nurse. aled 1 tablet signed out on 5/17, 8/26/17, 8/31/17 but the changed from 1/2 tablet. Ident #12 on 9/13/17 at 11:50 ated in her wheelchair in front e with a finished lunch tray on rossed; she was leaning to the one of the Annual MDS dated esident #3 scored 13 on the ewords. | F3 | 09 | | | |
| impairment. DRM CMS-2567(02-99) Previous Versions Obsolete Event ID: F0U711 Facility ID: TN1908 If continuation sheet Page 25 | ORM CMS-25 | | Obsolete Event ID: F0U711 | | Facility ID: TN1908 | If continu | ation sheet | Page 25 of 38 |

| | OC FOR MEDICAPE | & MEDICAID SERVICES | | | O | MB NO. | 0938-039 | }1 |
|--------------------------|--|--|--------------------|-----|---|-------------------|---------------------------|----|
| STATEMENT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l , , | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
| | | 445262 | B. WING | | | 09/1 | 3/2017 | |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 343 ASHLAND CITY HWY IASHVILLE, TN 37218 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETIO DATE | N |
| F 309 | dated 7/22/07 reveal Oxycodone 5/325 m Review of the Contr Resident #3 had Ox at 4:00 PM and aga apart by LPN #2. Th documented on the Record (MAR) as book Review of the facilit Administrator interv stated she had not be over a week. Medical record revie admitted to the facil including Coronary Hypertension, Seizu Peripheral Vascular Medical record revie dated 7/5/17 reveal the BIMS, indicating cognitively impaired Medical record revie designations and the services of th | ew of Physician's Orders aled Resident #3 was ordered ng every 6 hours as needed. rolled Drug Record revealed sycodone signed out on 9/6/17 in at 8:00 PM, not 6 hours nese doses were not Medication Administration eing administered. y investigation revealed the iewed Resident #3 and she had any pain medication in ew revealed Resident #15 was lity on 4/10/13 with diagnoses Artery Bypass Graft, ares, Diabetes Mellitus, or disease, and Dementia. ew of the Quarterly MDS and Resident #15 scored 7 on g she was moderately literated. | | 809 | | | | |
| | ordered Hydrocodol hours as needed for orders revealed this Review of the Contr Hydrocodone/APAP | aled Resident #15 was ne/APAP 5-325 mg every 6 r pain. Continued review of swas discontinued 6/9/17. Folled Drug Record revealed 9 signed out on 8/26/17 at 5:00 and 8/31/17 at 4:00 PM and 2. | | | | | | |
| ODM CMS 35 | 67/02 00) Provious Versions | Obsolete Event ID: F0U71 | 1 | Fac | cility ID: TN1908 If continuat | ion sheet F | age 26 of | 38 |

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | - 1 | J. 0938-0391 |
|--------------------------|--|---|--------------------|--------------------------|---|---------|----------------------------|
| STATEMENT AND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | TIPLE CONSTRUC | | | ATE SURVEY DMPLETED |
| | | 445262 | B. WING | | | 0 | 9/13/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 4343 ASHLAN NASHVILLE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (FAC | ROVIDER'S PLAN OF CORRECTH CORRECTIVE ACTION SHOW S-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 309 | Review of the facilit Administrator detern discontinued and thout. Observation of Res AM revealed she was eating lunch with not Medical record revie admitted to the facilitincluding Atheroscle and Falls. Medical record revie 9/1/17 revealed Resconfused. Medical record revied 9/1/17 revealed Resconfused. Medical record revied dated 9/1/17 revealed Hydrocodone/APAP needled. Review of the Contron 9/6/16 Resident Hydrocodone/APAP signed out at 4:00 Final Review of the facility DON determined the short an interval. Observation of Resident AM revealed him site eating lunch. He sai pain medication helimedical record review Medical record reviewed. | y investigation revealed the mined the order was e medication was still signed ident #15 on 9/13/17 at 11:40 as sitting in the dining room ocomplaints of pain. Ew revealed Resident #14 was ity on 9/1/17 with diagnoses erotic Cardiovascular Disease ew of nursing notes dated sident #14 was alert but Ew of Physician's Orders and Resident #14 was ordered of 10/325 mg every 6 hours as rolled Drug Record revealed #14 had received at 10:10 AM then it was PM and 9:00 PM by LPN #2. Ey investigation revealed the emedication was given at too ident #14 on 9/13/17 at 11:47 ting on the side of the bed do he was not in pain but the | F3 | 09 | | | |

| | RS FOR MEDICARE | & MEDICAID S | SERVICES | | | 0 | MB NO. | 0938-0391 |
|--------------------------|---|--|---|---------------------|-----|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SU | JPPLIER/CLIA | | | E CONSTRUCTION | | SURVEY PLETED |
| | | 445 | 262 | B. WING | | | 1 | 3/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABIL | ITATION INC | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 343 ASHLAND CITY HWY IASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS | TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF | ED BY FULL | ID PREFII TAG | X | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 309 | including Neck Frace Pulmonary Disease Failure, Pulmonary Disease, Atrial Fibriand Gastroesophage Medical record reviet dated 8/13/17 reveation the BIMS indicated able to make his new Medical record reviet dated 5/30/17 reveationed Hydrocodon hours as needed for Review of the Contre Hydrocodone signer then at 4:00 PM and Review of the facility DON determined the short an interval. Observation of the repulse PM revealed Resides stated he had no paramedications usually Medical record reviet admitted to the facility including Dressler's Cardiovascular Dise Mellitus, Atrial Fibrill Accident with Left Heipolar disorder. | cture, Chronic Co., Dementia, Co. Embolus, Chronillation, Pacema geal Reflux Dise ew of the Quartering he was aler- ing he was aler- ing he was aler- ineds known. ew of Physician aled Resident # ine/APAP 5-325 r pain. Folled Drug Record out on 9/6/17 di 9:00 PM by LF y investigation remedication was aler- in currently and a control the pain ew revealed Resident on 7/22/15 was alerted Resident, Cerebrowlemiplegia, aphalaministrator on diministrator on diministrator on different and control the pain alerted and control the pain aler | ngestive Heart nic Kidney aker Insertion, ease. erly MDS 17 scored 15 t, oriented, and 's Orders 17 was mg every 6 ord revealed at 10:10 AM PN #2. revealed the as given at too 8/17 at 2:40 in bed. He d his pain n. sident #16 was with diagnoses eriosclerotic sion, Diabetes wascular asia, and | F 3 | 609 | | | |
| ORM CMS-25 | 2:20 PM in the Adm | | e confirmed Event ID: F0U711 | | Fac | cility ID: TN1908 If continual | ion sheet | Page 28 of 38 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU A BUILDING | · · · · · · · · · · · · · · · · · · · | X3) DATE SURVEY COMPLETED |
|--|--|------------------------------|
| | | |
| 445262 B. WING | | C 09/13/2017 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDR | RESS, CITY, STATE, ZIP CODE | |
| CUMPEDI AND LIEALTH CADE AND DEHABILITATION INC | ND CITY HWY E, TN 37218 | |
| (EACH DESICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH | ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E COMPLETION ATE DATE |
| F 309 Continued From page 28 LPN #2 signed out medications more often than ordered by the Physician. Interview with the DON on 9/13/17 at 10:30 AM in the DON's office confirmed nurses failed to obtain a second signature when wasting narcotics for Resident #12 so did not follow facility policy. Continued interview the DON also confirmed on 9 occasions 1 tablet was signed out to be administered instead of the 1/2 tablet thus failing to follow Physician's Orders. Medical record review revealed Resident #10 was admitted to the facility on 4/9/12 with diagnoses including Bilateral Blindness, Type II Diabetes Mellitus, Vascular Dementia, Peripheral Vascular Disease, Gastro-Esophageal Reflux Disease, Bipolar Disorder, Arthropahty, Hypertension, Hypokalemia, Anemia, Rheumatoid Arthritis (RA), Stage 3 Pressure Ulcer of Left Buttocks & Muscle Wasting & Atrophy. Medical record review of the Quarterly Minimum Data Set (MDS) revealed Resident #10 had a Brief Interview for Mental Status of 4 indicating she was severely cognitively impaired. Further review revealed the resident had no impairment of the lower extremities and was not steady, only able to stabilize with staff assistance with moving from seated to standing position, moving on/off toilet and surface-to-surface transfer. Medical record review of a Clinical Note dated 5/18/17 revealed edema in right ankle. Resident #10 expressed facial grimaces when the nurse touched the ankle and declined to get out of bed. Medical record review of a Physician Assessment dated 5/19/17 revealed "Pt's [patient's] rt [right] | | |

| CENTER | S FOR MEDICARE | & MEDICAID S | SERVICES | | | | 01 | MB NO. 0 | 938-0391 |
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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SU | JPPLIER/CLIA | | TPLE CONSTRUCT | | | (X3) DATE S COMPL | |
| | | 445 | 262 | B. WING | | | | C 09/13 | /2017 |
| | ROVIDER OR SUPPLIER | E AND REHABIL | ITATION INC | | STREET ADDRES 4343 ASHLAND NASHVILLE, | | CODE | | |
| (X4) ID PREFIX TAG | | TEMENT OF DEFICION MUST BE PRECEDING INF | ED BY FULL | ID PREFIX TAG | (EACH | OVIDER'S PLAN OF CO CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY | N SHOULD E APPROPE | BE C | (X5) COMPLETION DATE |
| | Continued From parankle swollen, erythoted. Very painful precall any injury to a regarding pain to pte level for today which is seen to end of the findings showed condisplaced acute fractionabove the joint. Note that the distal tibia and continued is paint space. The born appears to be narrous there acute fracture findings Acute fractionabove the joint space. The born appears to be narrous there acute fracture findings Acute fractional fibula" Medical record reviets 5/19/17 revealed Resident to follow-undays. Review of a medical revealed Resident # appointment with an arrous fibula fracture findings Acute fractional fracture fibulation fracture | lemoatous, possible monatous, possible monatous, possible monatole. Was called ship ankle. Was called ship ankle. Was called ship ankle, ordered for the resident's right manuted and returne of the tibial ordered for the department (ED ew of a Radiological fibula, well hes are osteoped wing of the ank ship as seen. No other true of the distance of the distance of the distance of the distance which was significant which was significant which was significant with the possible of the distance | n. Pt doesn't ed last night ered uric acid will get xray" Note dated oner (NP) ght ankle. The mildly and fibula resident to be of the comminuted te fractures of above the enic. There le joint. No er incidental all tibia and cort dated a "tib-fib eplinted. In within 5 to 7 dated 7/21/17 equip ecialist. It is seen on May cility showed a laced in a ved up until | F 30 | 09 | | | | |
| | this week. She is he questioned her daug 7(02-99) Previous Versions | ghter why they r | never brought Event ID: F0U711 | | Facility ID: TN1908 | ŀ | f continuati | on sheet Pa | ge 30 of 38 |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | | E CONSTRUCTION | COM | E SURVEY PLETED |
| | | 445262 | B. WING | | | 09/ | 13/2017 |
| | ROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 43 | TREET ADDRESS, CITY, STATE, ZIP CODE 843 ASHLAND CITY HWY ASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | clearly showed her her today and the dithe nursing home wher right leg, she staprocurvatum deform equinus flexion condistal third extraartic 2 months ago, was followup and has no operative candidate orthopedic treatmer heal with risk of skir more palliative than nonunion of the tibia long termwe will psome stability at the will stimulate some month. We can cut x-rays and check or a candidate for a may be a good long Review of the medic until Sept 2017 reveseen by social serviceord dated 3/6/17[Resident #10] recon this date. A clinic and will be scanned review. This social we #10] with any social arise" Interview with the Segonsible for mak appointments. SW # | the followup information that I and that the daughter had with aughter says she just thought yould do itwhen we touched arted screamingThere is a nity at the right distal tibia and tracture of the ankleRight cular tib-fib fracture sustained seen in the ER and told to be until nowpatient is not an example. Will have to balance the not for trying to get the bone to no breakdown and this really is anything. She may have a set that we treat with bracing but her in a short leg cast for expression fracture site. Hopefully this healingwill see her back in a cast off, get another set of an her symptoms. She may be olded removable splint, that a term option for her" Cal records from January 2017 realed Resident #10 was never ces. Review of a medical by social services revealed "ceived mental health services cal note has been provided into the system for staff worker will assist [Resident services needs as they ocial Worker (SW) #1 on in his office revealed he was | F3 | 809 | | | |
| ORM CMS-256 | 7(02-99) Previous Versions (| Obsolete Event ID: F0U711 | | Fac | ility ID: TN1908 If continua | tion sheet | Page 31 of 38 |

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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | TIPLE CONSTRUCT | | COM | E SURVEY PLETED |
| | | 445262 | B. WING | | | 1 | C 1 3/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRES | SS, CITY, STATE, ZIP CODE | | |
| | | TAND DELIABILITATION INC | | 4343 ASHLAND | | | |
| CUMBER | RLAND HEALTH CARE | E AND REHABILITATION INC | | NASHVILLE, | TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH | OVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| F 514 | from the ED Physic not seen Resident # 2017-July 2017. Interview with the Add: 4:42 PM in her offic to ensure Resident orthopedic appoint orthopedic appoint of the Additional of the Additiona | ent #10 a follow-up as ordered ian. SW #1 then stated he had #10 from timeframe May dministrator on 9/12/17 at e confirmed the facility failed #10 received a follow-up nent as ordered. dministrator on 9/13/17 at she expected Social Services a residents at least quarterly if inistrator confirmed Resident seessed by Social Services LETE/ACCURATE/ACCESSIB with accepted professional tices, the facility must cords on each resident that mented; ple; and | F3 | | | | |
| | (5) The medical rec | | | | | | |
| | (i) Sufficient Informa | ution to identify the resident; Obsolete Event ID: F0U711 | | Facility ID: TN1908 | If continu | ation sheet | Page 32 of 38 |

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| | | 445262 | B. WING | | | l | 13/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | STREET ADDRESS, CITY, STATE, ZIP C 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 | OODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD | BE | (X5) COMPLETION DATE |
| F 514 | (iii) A record of the record (iii) The comprehen provided; (iv) The results of an and resident review determinations condition (v) Physician's, nursiprofessional's program (vi) Laboratory, radisservices reports as This REQUIREMENT by: Based on medical records for #5) of 17 residents of 17 residents of 17 residents of 18 record review admitted to the facil including Atheroscles Post Traumatic Stree Gastroesophageal Form Thrombosis, Diabet Chronic Pain. Medical record review and able to make his Medical record review and re | esident's assessments; sive plan of care and services my preadmission screening evaluations and ducted by the State; se's, and other licensed ess notes; and cology and other diagnostic required under §483.50. IT is not met as evidenced record review and interview, ensure complete and accurate 5 residents (#1, #2, #3, #4, reviewed. ed: ew revealed Resident #1 was ity on 8/1/17 with diagnoses rotic Cardiovascular Disease, ss Disorder, Reflux Disease, Deep Vein es Mellitus, Hypertension, and ew of the Admission Minimum ed 8/6/17 revealed Resident Brief Interview for Mental ating he was alert, oriented, s needs known. | F 5 | 14 | | | |
| | dated 8/6/17 revealed | ed Resident #1 was ordered | | | | | |

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| | | 445262 | B. WING | | | ı | C 1 3/2017 |
| | PROVIDER OR SUPPLIER | E AND REHABILITATION INC | | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 4343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 514 | hours as needed for Review of the Control 8/15/17, Oxycod out at 9:00 PM, 10:1 review revealed Ox on 8/16/17 at 6:00 A Medical record review Administration Record Oxycodone 7.5/325 administered at 3:4 PM on 8/16/17. Nor evening and night sevening sevening and night sevening and | milligrams (mg) every 6 r pain. rolled Drug Record revealed one 7.5/325 mg was signed 00 PM, 2:00 AM. Continued ycodone was also signed out AM. ew of the Medication ord (MAR) revealed mg was documented as 0 PM on 8/15/17 and at 1:33 ne of the other times from the hifts were documented on the hifts were documented on the eviewed on 8/16/17 and pain medication about 8:30 did not receive any pain he night on the 11:00 PM - e slept through the night. ew revealed Resident #2 was lity on 12/24/13 with diagnoses Mellitus, Hypertension, ive Sleep Apnea, Bipolar and Colostomy. ew of the Quarterly MDS ed Resident #2 scored 15 on she was alert, oriented, and eds known. | F 5 | 514 | | | |
| | | aled Resident #2 was ordered mg every 4 hours as needed | | | | | |

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| NAME OF I | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CUMBER | RLAND HEALTH CARI | E AND REHABILITATION INC | | | 343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 514 | Continued From pa Review of the Contro Oxycodone 7.5/325 AM, 2:00 AM, 6:00 a by Agency Nurse #1 Controlled Drug Review signed out at 11 documented as 29 and 27 after the tab review revealed only 2:00 AM but the coubefore the tablet was removed tablet was removed tablet was signed or was documented as removed and 23 aft Further review revealed only Agency Nurse #1 does and time. Medical review of the facility Resident #2 was into stated she received PM - 11:00 PM shift medication during the any increase in her particulating Hypertensing Diabetes Mellitus, D | rolled Drug Record revealed mg was signed out at 12:00 AM, 6:45 AM, and 6:55 AM, all f. Continued review of the cord revealed only 1 tablet 2:00 AM but the count was before the tablet was removed let was removed. Further y 1 tablet was signed out at unt was documented as 27 is removed and 25 after the . Continued review revealed 1 ut at 6:00 AM but the count is 25 before the tablet was removed. aled at 6:45 AM and 6:55 AM ocumented removing 2 tablets are MAR revealed Oxycodone cumented as administered on the found of but nothing was documented in was not having pain. The revealed Resident #3 was the revealed Resident #4 was the revealed Resident #4 was the revealed Resident #4 was the revealed Resident | F5 | 514 | DEFICIENCY) ** | | |
| ORM CMS-256 | 37(02-99) Previous Versions (| Obsolete Event ID: F0U711 | | rac | cility ID: TN1908 If continual | יטוו אווכפנ ו | Page 35 of 38 |

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| STATEMENT OF DEFICIENC AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | | LE CONSTRUCTION | | E SURVEY IPLETED |
| | | 445262 | B. WING | | | | C 13/2017 |
| NAME OF PROVIDER OR S | | E AND REHABILITATION INC | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| PREFIX (EACH DI | FICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETION DATE |
| BIMS indical impairment Medical rev 7/21/17 rev Oxycodone scheduled rev of the 8/5/17 reverout at 6:00 leads signed PM. Continu Oxycodone and 11:00 Per 9:30 PM, 10 PM. Further Oxycodone 12:00 AM, 60 Further reviews signed on 8/16/16 in AM, and 6:4 signed out be Medical record only docume documentat Oxycodone documentat Oxycodone Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the Medical record admitted to find the signed on the signed and the signed admitted to find the signed on the signed admitted to find the signed admitted adm | ealed Reating she string she string she string she string she side of Pealed Reating and sout at 6 and sout at 6 and sout at 6 and sout at 6 and sout at 4: was signed and sout at 4: to was signed at was signed at was signed at was signed at was signed and sout at 4: to was signed and south at a | esident #3 scored 13 on the had slight cognitive hysician's Orders dated esident #3 was ordered ng every 12 hours as a on. colled Drug Record dated ycodone 5/325/mg was signed 11:00 PM while on 8/6/17 it 1:00 AM, 5:00 PM, and 11:00 ew revealed on 8/7/17 ned out at 5:30 AM, 9:00 PM, on 8/9/17 it was signed out at and one was wasted at 11:30 revealed on 8/10/17 ned out at 6:00 AM and on out at 12:00 AM and 6:00 ew revealed on 8/14/17 ned out at 12:00 AM, again for 6:30 AM, and 6:50 AM. ealed on 8/15/17 Oxycodone 10:00 PM while gned out at 12:00 AM, 6:00 all of these removals were | F 5 | 14 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | | LE CONSTRUCTION | (X3) DATE | |
| | | 445262 | B. WING | | | | 13/2017 |
| NAME OF PROVIDER OR SUPPLIER | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CUMBERLAND HEALTH CARE AND REHABILITATION INC | | | | | I343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX (E TAG CRO | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEMENCY) | OTHE APPROPRIATE | |
| F 514 | Continued From page | ge 36 | F 5 | 514 | | | |
| | Medical record review of the Admission MDS dated 7/27/17 revealed Resident #4 scored 15 on the BIMS, indicating he was alert, oriented, and able to make his needs known. | | | | | | |
| | dated 7/20/17 revea | ew of Physician's Orders led an order for Oxycodone 5 or 6 hours as needed for pain. | | | | | |
| | on 8/5/17 Oxycodor and 11:45 P0 AM; o 2:00 AM; on 8/13/17 on 8/14/17 it was sig 6:00 AM; on 8/15/17 and on 8/16/17 it was | rolled Drug Record revealed he was signed out at 6:15 PM in 8/12/17 it was signed out at 7 it was signed out at 12:00 AM and 7 it was signed out at 7:00 PM as signed out at 1:00 AM. All he signed out by Agency Nurse | | | | | |
| | | ew of the MAR revealed no nee MAR of any of these dministered. | | | | | |
| | admitted to the facili including Acute Res Pneumothorax, Cere | ew revealed Resident #5 was ity on 4/28/17 with diagnoses piratory Failure, Tension ebrovascular Accident with ypertension, and Chronic | | | | | |
| | dated 8/1/17 revealed | ew of the Quarterly MDS ed Resident #5 scored 3 on she was severely impaired | | | , | | |
| | | w of Physician's Orders led Resident #5 was ordered g three times daily. | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED | |
| | | 445262 | | | | | C 09/13/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | *** | |
| CUMBERLAND HEALTH CARE AND REHABILITATION INC | | | | | 3343 ASHLAND CITY HWY NASHVILLE, TN 37218 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHO | | _D BE COMPLETION | |
| F 514 | Continued From page Review of Controlle revealed Oxycodone 10:00 PM, 11:00 PM 11:30 PM. Continue Oxycodone was sig 10:30 PM, and 11:00 on 8/6/17 Oxycodone 5:00 PM, and 11:00 revealed on 8/12/17 at 12:00 AM, 4:00 A 8/13/17 it was signe AM. Further review Oxycodone was signe AM while on 8/15/17 PM, 10:30 PM, 12:00 removals were all si #1. Medical record review of these removals were all si #1. Interview on 9/13/17 Administrator's office medications were now when signed out on | d Drug Record dated 8/3/17 e was signed out at 5:00 PM, fl, again at 11:00 PM, and d review revealed on 8/4/17 ned out at 5:00 PM, 5:30 PM, floop PM. Further review revealed floop was signed out at 5:00 AM, floop PM. Continued review floop Continued review floop Continued review floop AM while on floop and 6:00 AM while on floop and out at 12:00 AM and 6:00 floop and at 12:00 AM and 6:00 floop and at 12:00 AM. These floop and out by Agency Nurse floop and floop and floop | F 5 | = | DEFICIENCY) | | |
| 1 | | | | | | | |